

Diagnosis Related Groups: Billing for Beneficiaries with California Children Services Eligible Conditions and/or Managed Care

BACKGROUND:

The California Children's Services (CCS) reimburses providers for services to Medi-Cal eligible children with specified conditions through a Fee-For-Service (FFS) system, with some exceptions. Payments to hospitals for these services align with the payment methodology utilized for all other Medi-Cal FFS services.

Many Medi-Cal beneficiaries with CCS-eligible conditions are also enrolled in a Medi-Cal Managed Care Plan (MCP). Most MCP contracts do not cover CCS services; however, the MCPs are responsible for providing medically necessary services that are not related to the CCS condition. Until the implementation of the Diagnosis Related Group (DRG) payment methodology, inpatient services provided at a private hospital to Medi-Cal MCP beneficiaries for CCS-eligible conditions that were not covered by the MCP were paid through the Fee-For-Service (FFS) system. Payments were based on the number of days authorized on a CCS Service Authorization Request (SAR). If a Medi-Cal MCP beneficiary was hospitalized for a CCS-eligible condition, as well as a condition covered by the MCP, providers were required to bill through the FFS system for the days covered by the CCS SAR, and bill the MCP for the days covered by the MCP. This is called billing by payer source.

REQUIREMENTS:

Effective July 1, 2013, private hospitals are no longer reimbursed by Medi-Cal FFS on a per diem basis. The DRG methodology now reimburses hospitals for the entire stay of the patient, with payments being higher or lower based on acuity and not on length of stay. Under the DRG system, only an admission SAR or Treatment Authorization Request (TAR) is required to approve an inpatient stay for beneficiaries with full-scope Medi-Cal aid codes; therefore, providers cannot bill multiple payers for an inpatient stay that includes managed care and CCS days. Non-Designated Public Hospitals, currently paid under a per diem, will switch to a DRG payment methodology beginning January 1, 2014. At that time, this policy will also apply to these hospitals.

Therefore, for days of service effective July 1, 2013, and for private hospital stays, the following billing policy will apply for services provided to Medi-Cal beneficiaries with CCS-eligible conditions who are enrolled in an MCP that does not cover CCS-eligible conditions:

- If a beneficiary is admitted to a hospital for a CCS-eligible condition, the entire stay should be billed through the FFS system, regardless of whether any services provided during that stay may be covered by a MCP. MCPs should not be billed for this stay. The hospital will receive one payment for the entire stay, based on the DRG for that stay.
- If a beneficiary is admitted to a hospital for a non-CCS eligible condition and subsequently receives services during the stay for a CCS-eligible condition, the full stay should be billed through the FFS system. A SAR will be authorized back to the day of admission. MCPs should not be billed for this stay. The hospital will receive one payment for the entire stay based on the DRG for that stay.
- When a beneficiary stay includes delivery and well-baby coverage under an MCP, the entire claim will be billed to the MCP. If, during the stay, the baby develops a CCS-eligible condition, the entire stay for the baby will require a SAR from the date of admission and should be billed through the FFS system. MCPs should not be billed for the baby's stay. In this case, the hospital will receive two payments, one for the delivery and well-baby stay from the MCP, and one for the baby under the DRG.

If you have any questions regarding this policy, or any other DRG policy, please contact us at DRG@dhcs.ca.gov or visit us at our web page at <http://www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx>.